COMPUTER LEARNING CENTER

STUDENT REQUEST
FOR
VERIFICATION OF COMPLETION

Name: _____ Social Security Number: _____/____/_____

Address: _____

_____

Telephone: _____-_____-_____ **Date of Birth: _____/_____/_____**
Month Day Year

Name at time of certification (if different): _____

Program Completed: _____

Date Started: _____ Date Completed: _____

Campus attended: _____ Paramus _____ Cherry Hill _____ South Plainfield
(Please Check only one)

E-Mail Address (*if applicable)***: _____**

I, _____, hereby certify that the information above is true and
Print your Name

correct to the best of my knowledge.

_____ _____
SIGNATURE DATE

Return to:

Dr. Thomas A. Henry, Director
Office of School to Career and College Initiatives
N.J. Department of Education
P.O. Box 500
Trenton, N.J. 08625-0500